Report on an unannounced short follow-up inspection of

HMP Channings Wood

5 – 8 July 2010

by HM Chief Inspector of Prisons

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Contents

1 Introduction 5

2 Fact page 7

3 Healthy prison assessment 9

4 Progress since the last report 15

5 Summary of recommendations 43

6 Appendices

I Inspection team 51
II Prison population profiles 52

Introduction

Channings Wood is a purpose built category C training prison for adult males in rural Devon. On our last visit, we commended the prison for providing a largely safe and purposeful environment in the face of mounting population pressures. This short unannounced follow-up inspection found that, overall, Channings Wood had sustained much of the good work we had previously identified but there remained scope for improvement. In particular, we set out some increased concerns over safety.

Although the prison appeared generally safe, we were particularly worried about LB3 unit. Like other units, the design made it difficult to supervise but it appeared much less settled or well kept compared to other parts of the prison and we were told by prisoners about drug dealing, intimidation and assaults. We were also not assured that the establishment's generally sound anti-bullying and violence reduction arrangements were being implemented effectively on the unit.

Happily, the situation on LB3 was not replicated elsewhere. Early days were generally well managed, suicide and self-harm reduction arrangements were sound and the mix of vulnerable prisoners housed together was now more closely monitored. Efforts had been made to improve security and, despite peaks and troughs, substance misuse did not appear out of control. Aspects of the segregation unit had improved but it remained a poor facility.

Relationships between staff and prisoners varied, and would have been helped by more consistent personal officer work. The quality of accommodation also varied but, apart from LB3, was generally adequate. Not all aspects of diversity received adequate attention, but the management of race equality was sound. Health care services remained reasonably good.

Channings Wood remained a generally purposeful prison with some good quality work and education opportunities, and a much increased range of vocational qualifications. However, there was still not enough purposeful activity to keep all men occupied every day and those who were unemployed spent too long locked in their cells. PE provision was good.

The strategic management of resettlement was generally satisfactory but for many prisoners reintegration and contact with family and friends remained hampered by being held far from home in rural Devon. Offender management was good, with generally up-to-date assessments and a good range of interventions to address offending behaviour, including an effective therapeutic community for those with drug problems. Services to prepare prisoners for release had improved.

Channings Wood continued to be a reasonable training prison, providing a generally safe and purposeful environment, together with well managed resettlement arrangements. However, there remained a need for more activities to ensure that all prisoners are able to take part regularly in work or training, and we had a particular concern about one apparently unsettled unit, which was less safe and more squalid than other parts of the prison.

Nigel Newcomen — September 2010
HM Deputy Chief Inspector of Prisons

Fact page

Task of the establishment
Channings Wood is a category C training prison.

Prison Service operational area
South West

Number held
729

Certified normal accommodation
698

Operational capacity
731

Date of last full inspection
2 – 6 July 2007

Brief history
The site of Channings Wood was acquired from the Ministry of Defence by the Prison Service in 1970 and officially opened in July 1974. Channings Wood is now a purpose-built training prison for prisoners serving short, medium and long-term determinate and indeterminate sentences. The prison also holds up to 60 places for life-sentenced prisoners. It has three distinct areas: the main prison, the drug therapeutic community and a vulnerable prisoner unit.

Description of residential units

- LB1: Operational capacity 139 – Mersey wing 56 single cells (roll 56)
  Thames wing 29 single cells, 27 double cells (roll 83)
- LB2: Operational capacity 112 – Clyde wing 56
  Severn wing 56
- LB3: Operational capacity 112 – Exe wing 56
  Dart wing 56
- LB4: Operational capacity 112 – Avon wing 56
  Humber wing 56
- LB5: Operational capacity 118 – Weaver wing 28 single cells, 3 double cells (roll 59)
  Fleet wing 28 single cells, 3 double cells (roll 59)
- LB6: Operational capacity 34 – Plym wing 34
- LB7: Operational capacity 40 – Otter wing 40
- LB8: Operational capacity 64 – Beauly wing 32 double cells (64 prisoners), which houses the therapeutic community

Section 1: Healthy prison assessment

Introduction

HP1 The purpose of this inspection was to follow up the recommendations made in our last full inspection of 2007 and examine progress achieved. We have commented where we have found significant improvements and where we believe little or no progress has been made and work remained to be done. All inspection reports include a summary of an establishment's performance against the model of a healthy prison. The four criteria of a healthy prison are:

Safety	prisoners, even the most vulnerable, are held safely
Respect	prisoners are treated with respect for their human dignity
Purposeful activity	prisoners are able, and expected, to engage in activity that is likely to benefit them
Resettlement	prisoners are prepared for their release into the community and helped to reduce the likelihood of reoffending.

HP2 Under each test, we make an assessment of outcomes for prisoners and therefore of the establishment's overall performance against the test. In some cases, this performance will be affected by matters outside the establishment's direct control, which need to be addressed by the National Offender Management Service.

- outcomes for prisoners are good against this healthy prison test.
There is no evidence that outcomes for prisoners are being adversely affected in any significant areas.

- outcomes for prisoners are reasonably good against this healthy prison test.
There is evidence of adverse outcomes for prisoners in only a small number of areas. For the majority, there are no significant concerns. Procedures to safeguard outcomes are in place.

- outcomes for prisoners are not sufficiently good against this healthy prison test.
There is evidence that outcomes for prisoners are being adversely affected in many areas or particularly in those areas of greatest importance to the well being of prisoners. Problems/concerns, if left unattended, are likely to become areas of serious concern.

- outcomes for prisoners are poor against this healthy prison test.
There is evidence that the outcomes for prisoners are seriously affected by current practice. There is a failure to ensure even adequate treatment of and/or conditions for prisoners. Immediate remedial action is required.

HP3 This Inspectorate conducts unannounced follow-up inspections to assess progress against recommendations made in the previous full inspection. Follow-up inspections are proportionate to risk. Short follow-up inspections are conducted where the

previous full inspection and our intelligence systems suggest that there are comparatively fewer concerns. Sufficient inspector time is allocated to enable inspection of progress and, where necessary, to note additional areas of concern observed by inspectors. Inspectors draw up a brief healthy prison summary setting out the progress of the establishment in the areas inspected. From the evidence available they also concluded whether this progress confirmed or required amendment of the healthy prison assessment held by the Inspectorate on all establishments but only published since early 2004.

Safety

HP4 In 2007, Channings Wood was performing reasonably well against this healthy prison test. Out of 46 recommendations in this area, 22 had been achieved, six partially achieved and 18 not achieved. We have made 10 further recommendations.

HP5 Most prisoners who arrived during the inspection came from HMYOI Portland and did not have long journeys, but many had been told of their transfer to Channings Wood only on the morning of the move. A number of other prisoners who had experienced longer journeys said they had not been offered toilet breaks. The reception area was clean and staff were friendly and relaxed, but holding rooms were unsupervised. Vulnerable prisoners often had to wait a long time in reception as they were dealt with last. Cell-sharing risk assessments and first night interviews were now completed in private in reception.

HP6 There were suitable first night procedures. Most prisoners could shower and make a telephone call shortly after arrival, but this was not the case for men who arrived later in the day. National allocations to Channings Wood took no account of specialist regimes and lack of space elsewhere in the prison meant some new arrivals had to stay temporarily in the therapeutic community, which was inappropriate. All prisoners, including vulnerable prisoners, now got a similar quality induction, but this did not start the day after arrival or fully occupy them.

HP7 Although the prison appeared generally safe, LB3 did not appear as safe or settled as other units and prisoners described instances of drug dealing, intimidation and assaults. The design of all units meant they were difficult to supervise and there was still no close-circuit television cover. Despite anecdotal accounts from prisoners of bullying and intimidation, particularly in relation to drugs and debts, these were not reflected in the use of the formal anti-bullying procedures. Even in cases where there had been documented assaults, the violence reduction and anti-bullying procedures had not been used. Very few residential staff had received appropriate training. Staff culture and the need for staff to be more aware of the signs of intimidation, particularly when it was not physical, had been identified as issues to be addressed. There were now some interventions to support victims, but little to confront and challenge bullies. Better attention was now given to monitoring the mix of sex offenders and non-sex offenders on LB5 to help ensure safety.

HP8 There was a good up-to-date and comprehensive suicide and self-harm policy. The assessment, care in custody and teamwork (ACCT) registers were well maintained and investigations into near-fatal incidents were undertaken to see what lessons could be learned. Incidents of self-harm had increased significantly in the previous two years, but much of this was down to a small number of men who repeatedly self-harmed. Although all senior officers had been trained as case managers, some of the

ACCT documents we examined indicated some unsatisfactory assessments and reviews with little consistency of case management and few staff from other disciplines represented. While we saw some good examples, the overall quality of ACCT procedures and daily entries in monitoring documents needed some improvement.

HP9 Some action had been taken to reduce the number and impact of roof top incidents. Analysis of adjudications, use of force and segregation had improved, but there was potential to develop this further to identify trends, particularly by location. Regular adjudication meetings were held to review punishment levels and other relevant issues. Quality assurance of adjudications was undertaken by the governor, who provided feedback as necessary. Some additional activities had been introduced in the segregation unit, but the regime was fairly constrained for prisoners who were refusing to relocate. The segregation exercise yard remained poor. Segregation unit staff were supportive and history sheet entries recorded some good interaction with prisoners, but better targets in care plans were needed.

HP10 The yearly mandatory drug testing (MDT) positive rate for 2009/10 had been 6%, which was the target figure. This masked variations between different parts of the prison and there was still no formal analysis by wing to identify problem areas. There were also some wide variations between months, with the MDT positive rate as high as 17% in one recent month. In recent months, most MDT tests were carried out towards the end of the month, which gave an indication to prisoners when they were less likely to be tested. The introduction of the integrated drug treatment system had helped improve clinical management services for drug users and there was effective joint working between the counselling, assessment, referral, advice and throughcare (CARAT) service and health care, but there were no specific protocols for secondary detoxification.

HP11 On the basis of this short follow-up inspection, we considered that outcomes for prisoners remained reasonably good against this healthy prison test.

Respect

HP12 In 2007, Channings Wood was performing reasonably well against this healthy prison test. Of the 60 recommendations in this area, 26 had been achieved, seven partially achieved, 22 not achieved and five were no longer relevant. We have made 12 further recommendations.

HP13 Staffing levels were tight on units. Most residential officers were based in wing offices a lot of the time, which meant opportunities for informal interactions between staff and prisoners were relatively restricted. Officers invariably used surnames alone when referring to or addressing prisoners. Prisoners in groups said they found many officers unhelpful and often 'fobbed them off', but they also recognised that there were some who went out of their way to support them. There was a satisfactory personal officer policy, but no training for what was required and the personal officer scheme did not appear to be very active or effective. Most personal officer wing file entries said very little about the prisoner other than his behaviour on the unit. Very few entries referred to sentence plan targets or family issues.

HP14 The general environment of the prison was good. Shared cells were cramped and, despite some refurbishment, many shower areas were in poor condition. Most living

units were clean and well looked after, but LB3 was in very poor condition. There was some limited monitoring of time taken to answer cell bells, but the response took too long in one we tested. Most prisoners had to wear prison clothes and it was unreasonable that the few who could wear their own clothes on two enhanced units were not allowed to wear them off the units.

HP15 A draft diversity policy was used, but did not cover all diversity strands such as sexuality. There was reasonably good initial identification of prisoners with disabilities, but insufficient physical adaptations to meet need and no formal carer scheme for those needing additional support. Diversity representatives were elected by other prisoners and active in the prison. Race relations work was positive and racist incident report forms were thoroughly investigated and scrutinised. Ethnic monitoring was detailed and covered areas of concern to prisoners such as wing orderly jobs. No black and minority ethnic prisoner groups where relevant information could be shared had been held for some time. Very few foreign national prisoners were now held at Channings Wood and there was generally appropriate provision to meet their individual needs.

HP16 Prisoners had mixed views about the quality of the food. Many agreed that the quality was mostly reasonable, but a number said the portions were inadequate. Meals times during the week were at more appropriate times than previously and it was good to see that breakfast continued to be provided each morning rather than breakfast packs issued the day before. Shop arrangements appeared satisfactory. A reasonable standard delivery charge was charged for all catalogue orders and a locally imposed administrative charge was no longer levied.

HP17 There was good monitoring of complaints, which were appropriately analysed by subject, including those submitted under confidential access. However, many prisoners complained that they had to repeat or chase up applications. Applications were not tracked or monitored so it was not possible to establish the true position.

HP18 Health care was better integrated into the work of the prison. Overall services were reasonably good, but there was no patients' forum to inform the development of services and communicate issues clearly to prisoners. Some good services, such as a special health care clinic, were run for older prisoners, but there was no day care service for them or other prisoners who found it difficult to cope on the units. A programme of mental health awareness training for staff had just begun. Resuscitation training was not delivered frequently enough. Formal nurse triage algorithms have been introduced for some specialist areas, but needed to be implemented more widely. Medicines and pharmacy policies were not up to date.

HP19 On the basis of this short follow-up inspection, we considered that outcomes for prisoners remained reasonably good against this healthy prison test.

Purposeful activity

HP20 In 2007, Channings Wood was performing reasonably well against this healthy prison test. Of the 13 recommendations in this area, six had been achieved and seven not achieved. We have made no further recommendations.

HP21 Time out of cell was reasonably good for those in full-time activities, but too many prisoners were unemployed and spent most of the day locked in their cells. Older

retired prisoners also spent too much time locked up, although much depended on the discretion of officers, which was unsatisfactory. Prisoners had regularly scheduled time in the open air. The grounds were attractive areas for exercise and association, but there was no seating even though the prison held a relatively high proportion of older men.

HP22 There were still too few activity places to ensure that all men could be purposefully occupied during the day, but the quality of the education and training appeared generally good. Additional library sessions had been scheduled for vulnerable prisoners, but were often cancelled.

HP23 With insufficient work available, about 18% of prisoners were classed as unemployed. Many waited too long to be allocated jobs and not all jobs kept men fully occupied, but the workshops were well organised and productive and prisoners working there gained useful and relevant employment related skills. The range and number of accredited training courses offered alongside employment in the workshops had increased significantly and there was a wider range of more appropriate qualifications, which more prisoners were following. Learning pods had been successfully installed in all workshop areas and were effectively used by prisoners to work on qualification portfolios and to receive additional literacy and numeracy support while remaining in the work place.

HP24 PE facilities were good. The roof to the sports hall had been repaired and better use was now made of the facility. An activity trail had increased the outside exercise area and prisoners made good use of the grounds. One additional member of PE staff had been appointed, which allowed more recreational PE sessions to be run during the core day.

HP25 On the basis of this short follow-up inspection, we considered that outcomes for prisoners remained reasonably good against this healthy prison test.

Resettlement

HP26 In 2007, Channings Wood was not performing sufficiently well against this healthy prison test. Of the 35 recommendations in this area, 19 had been achieved, six partially achieved, eight not achieved and two were no longer relevant. We have made 11 further recommendations.

HP27 A reasonably good resettlement strategy covered all the resettlement pathways. Targets in the associated action plan were now more specific and measurable, but not all the pathway areas had targets set. Some resettlement needs analysis had been completed, but this was mainly related to offending behaviour and specific interventions and referrals rather than areas such as contact with children and families, which was a particular issue as many men were a long way from home.

HP28 The offender management unit was now well established. The offender supervisors' case notes showed good knowledge of the prisoners and their circumstances, so it was surprising that many prisoners said they had relatively little contact with their offender supervisors. Most offender assessments and sentence plans were up to date. Although there was no formal custody plan for the small percentage of prisoners serving less than 12 months, all prisoners were allocated an offender supervisor who

interviewed them shortly after arrival and made appropriate referrals to resettlement services.

HP29 A good range of programmes continued to be run to a high standard, although some men serving life sentences could still wait some time to begin them. Previous delays in assessments for programmes had been addressed. Significant delays with completion of structured assessments of risk and need (SARN reports) following completion of the sex offender treatment programme had been a key problem at the previous inspection, but commendably were now all up to date. Some men were unable to progress to other prisons to take part in courses identified for them because escorts were frequently cancelled.

HP30 Improved accommodation services were now provided by the St Giles Trust. All prisoners were seen by trained prisoner housing representatives shortly after arrival and referrals made if necessary. The recorded rate for prisoners released without fixed accommodation to go to was now 10% compared to the previous 20%. A JobCentre Plus worker helped with benefits and finance, and debt advice was also provided. Prisoners were very positive about the information and advice service and some good courses were run to help prepare prisoners for release.

HP31 Visits facilities were good and all visits, including those for vulnerable prisoners, now took place in the main visits hall. Visitors said they were well treated except that visits did not start at the advertised time. Some good children and family days were run, but none had been planned for vulnerable prisoners since December 2009. Some positive initiatives had been developed to help men keep in touch with their families, including relationship support through Relate, but the importance of maintaining family ties to help reduce reoffending was not embedded in residential and personal officer duties and was often seen as specialist work.

HP32 The drug and alcohol strategy was up to date, but not based on an analysis of the substance use needs of the population. More one-to-one structured interventions were provided through the drug workers and there was some limited support for those with alcohol problems. The drugs therapeutic community operated effectively, but it was difficult to fill the 64 places on the wing and as a result too many other prisoners not involved in therapy were held there temporarily.

HP33 On the basis of this short follow-up inspection, we considered that outcomes for prisoners were now reasonably good against this healthy prison test.

Section 2: Progress since the last report

The paragraph reference number at the end of each recommendation below refers to its location in the previous inspection report.

Main recommendations (from the previous report)

2.1 A full-time safer custody manager should be appointed to ensure that the anti-bullying strategy is robustly managed, and that staff are aware of and understand their responsibilities to ensure that all incidents of suspected bullying are logged and investigated. (HP40)
Not achieved. A senior officer appointed as safer custody manager after the last inspection had recently been replaced by an officer. She was competent, had a good understanding of managing safer custody and was well supported by her line manager, but did not have sufficient authority to change staff practices and attitudes to ensure quality anti-bullying arrangements. Wing staff had not been trained in local anti-bullying procedures and the records showed that wing managers placed individuals on monitoring only when there was clear physical evidence of bullying. One senior officer had interviewed a prisoner who said he was being bullied and named two prisoners responsible, but had recorded no evidence of bullying because it was one man's word against two. None of the prisoners, including victims, involved in the nine serious assaults recorded to date in 2010 had been placed on formal anti-bullying procedures. Prisoners described numerous incidents of bullying and intimidation, particularly linked to drugs and debts, but these were not reflected in the use of formal anti-bullying procedures.
We repeat the recommendation.

2.2 A strategy with clear objectives should be agreed to reduce the supply of drugs in the prison and the consequent violence. (HP41)
Partially achieved. There was a document entitled the drug supply reduction strategy, but it was little more than a list of available resources. Risks and issues particular to Channings Wood had not been identified, so no objectives or strategies had been set to address them.
We repeat the recommendation.

2.3 An up-to-date personal officer policy should be agreed and clear training and guidance given to officers about the role and what is expected of them. (HP42)
Partially achieved. There was a current personal officer policy and personal officer duties were set out in staff performance and development review targets. However, there was no specific training for personal officers, which was reflected in much of the routine personal officer work we observed and in some inadequate comments in history sheets and how prisoners experienced the scheme.

Further recommendation

2.4 Specific training for personal officers should be introduced so that they are fully aware of what is required of them and the standards expected.

2.5 A diversity policy should be published that meets the requirements of anti-discrimination legislation and outlines how the needs of all minority groups will be met. (HP43)

Not achieved. The diversity policy was in draft, excluded sexuality, was not based on a needs analysis and did not include an action plan describing how the needs of all minority groups would be met.

Further recommendation

2.6 The diversity policy should include all diversity strands, be based on a needs analysis of the population and include an action plan to describe how the needs of all minority groups will be met.

2.7 All prisoners should have a minimum of 10 hours a day out of cell including at least one hour in the open air. (HP44)
Not achieved. The weekday regime did not allow any prisoners to have a minimum of 10 hours a day out of cell, even those in full-time work who had evening association. Prisoners had regularly scheduled time in the open air between 11am and noon. Those employed in morning activities were allowed time in the open air in the afternoon and all had time outside during the evening in the summer months.
We repeat the recommendation.

2.8 Sufficient activity places should be provided to keep all men at Channings Wood purposefully occupied. (HP45)
Not achieved. The number of activity places had increased from 500 to 589 full and part-time places. However, the number of prisoners had also increased from 667 to 722, so there were not enough places to keep all men purposefully occupied.
We repeat the recommendation.

2.9 A detailed resettlement needs analysis should be completed across all resettlement pathways, taking into account diversity issues, to inform the development of the resettlement strategy and the provision of services. (HP46)
Partially achieved. The reducing reoffending strategy included information about prisoners taken from the assessment of need interview. This mostly involved factual information, such as sentence length, offence, age, discharge area and physical and mental health, but did not cover areas such as substance misuse or contact with family and friends.
We repeat the recommendation.

2.10 All eligible prisoners should have an up to date OASys assessment and sentence plan, and the resettlement needs assessment should be adapted to operate as a custody plan for those serving less than 12 months. (HP47)
Achieved. Most prisoners had an up to date OASys assessment and sentence plan. The resettlement needs assessment had been replaced by an initial assessment of need interview, completed by the prisoner's allocated offender supervisor during induction including for the small number of prisoners serving less than 12 months. Although there was no formal custody plan, prisoners were informed about any referrals made on their behalf.

2.11 Channings Wood should not routinely be used to imprison men who live over 100 miles away. (HP48)
Not achieved. Although better than previously, there were approximately 38% of prisoners over 100 miles from home.
We repeat the recommendation.

Recommendations

Courts, escorts and transfers

2.12 Prisoners should be given regular comfort breaks. (1.6)
Achieved. Although some prisoners complained that they had not been offered toilet breaks during their journey, this did not apply to any of those arriving during the inspection.

2.13 Agreed transfers should be arranged without undue delay. (1.7)
Not achieved. Booked transport was still regularly cancelled for some prisoners. Most of the 12 prisoners transferring elsewhere had been waiting since May 2010, but one man due to move to HMP Erlestoke to join a drug programme had been waiting since 12 March 2010 and his transfer had already been cancelled 17 times.
We repeat the recommendation.

Additional information

2.14 Some prisoners arriving from HMYOI Portland had been told of their move only that morning.

Further recommendation

2.15 Prisoners should be given 24-hours notice of planned transfers.

First days in custody

2.16 Cell-sharing risk assessments and first night officer interviews should be completed in private. (1.28)
Achieved. The cell-sharing risk assessment and reception interview were completed in private in reception.

2.17 All reception holding rooms should be able to be observed by staff. (1.29)
Not achieved. An observation window had been installed in the door between reception and the holding rooms for prisoners who had completed the reception process, but the door was kept shut and the window closed. Consequently, prisoners in these rooms could not be observed.
We repeat the recommendation.

2.18 Information should be provided in languages other than English and reception staff made aware of it. (1.30)
Achieved. Reception officers knew they could use a professional telephone interpreting service and that information in a range of languages was available on the intranet.

2.19 New arrivals should be able to shower on the day of arrival. (1.31)
Not achieved. Prisoners who arrived on the wings near to evening lock-up could not shower until the next day.
We repeat the recommendation.

2.20 Formal first night and induction procedures should apply to all prisoners irrespective of their location. (1.32)

Achieved. First night and induction procedures applied to all prisoners, including vulnerable prisoners.

2.21 All the information displayed in the induction presentation should be read to prisoners, and the quality of content regularly monitored and evaluated by prisoners and managers. (1.33)
Partially achieved. Information in the induction presentation was read to prisoners. However, although prisoner induction evaluation forms had been introduced, no formal evaluation had taken place on the main wings since July 2009. Evaluation for vulnerable prisoners continued and the feedback provided had led to some recent changes.

Housekeeping point

2.22 Evaluation of induction questionnaires should be reintroduced for prisoners on the main wings.

2.23 The induction programme should start the day after arrival and should fully occupy prisoners. (1.34)
Not achieved. The formal induction programme still began on Mondays and did not fully occupy prisoners.
We repeat the recommendation.

Additional information

2.24 Reception was clean and new arrivals were offered a hot or cold drink. Reception staff were polite, but they and health care staff in reception addressed prisoners by surname alone, if at all. Prisoners could wait several hours in reception. Some men who arrived at 2.45pm on one day of the inspection did not get to their allocated wing until after 7pm. Vulnerable prisoners were usually dealt with last and waited the longest. Holding rooms used for new arrivals contained televisions, but had no general reading material, and the two rooms used for those who had completed the reception process contained nothing to pass the time. New arrivals were often 'lodged' on the therapeutic community (TC), sometimes for several weeks, while waiting for a space on the main first night and induction wing. Many prisoners involved in therapy found this frustrating and distracting.

Further recommendations

2.25 Prisoners should be held in reception for as short a time as possible.

2.26 The therapeutic community should not be used as an overflow wing for new arrivals.

Residential units

2.27 Cells designed for one should not be used to accommodate two prisoners. (2.12)
Not achieved. Single cells on both LB1 and LB5 were still used for two prisoners.
We repeat the recommendation.

2.28 In-cell toilets in shared cells should be adequately screened. (2.13)
Achieved. All cell toilets in shared cells had been screened using floor-to-ceiling shower curtains.

2.29 Cell call bells should be answered promptly and in the absence of an auditable system, duty governors should check response times routinely. (2.14)
Not achieved. Management checks on cell call bell response times were carried out only by senior officers and only once a month on each unit. We tested a call bell and waited over seven minute for a response. A new electronic monitoring system was being installed and would allow comprehensive scrutiny of response times by senior managers.

2.30 Shower areas should be refurbished and individual shower cubicles should be provided. (2.15)
Not achieved. Communal shower areas on LBs 1 to 5 had not been divided into individual cubicles and had received only minimal ongoing repairs. Some were very poor, particularly on LB3, with one shower area closed and the second used to store cleaning machinery.
We repeat the recommendation.

2.31 All prisoners should be able to wear their own clothes. (2.16)
Not achieved. Only prisoners on LB6 and LB7 were allowed to wear their own clothes and had to wear prison clothing when going off the units, even for visits.
We repeat the recommendation.

Additional information

2.32 External areas and most units were very clean, but LB3 had litter in corridors and the fabric of the building was in poorer condition than other units and looked uncared for. The operation of LB3 had been identified as a major issue and a developing Prison Service manager had been allocated an office there, but there was little evidence of much improvement.

Further recommendation

2.33 The condition and cleanliness of LB3 should be to the same standard as that of the other units.

Staff-prisoner relationships

2.34 Staff should treat prisoners with respect in the way they speak to them, using first name or title according to each prisoner's personal preference. (2.25)
Not achieved. Staff almost invariably referred to and spoke to prisoners using their surnames alone. The prison's action plan indicated that pro-social modelling training would be needed to change this, but there were no funds for it. No guidance to staff on how to address prisoners had been issued.
We repeat the recommendation.

2.35 Officers should patrol the wings regularly during association to allow informal interaction with prisoners, provide a reassuring presence and improve dynamic security. (2.26)
Not achieved. During association, officers were mostly based in wing offices or involved in other tasks on and off the wing, including supervising exercise. This left little opportunity for regular patrols of the wing or to engage informally with prisoners.
We repeat the recommendation.

Personal officers

2.36 Personal officers should get to know prisoners' personal circumstances and record contact in wing files to build up an accurate chronological account of a man's time at Channings Wood, his achievement against sentence plan and resettlement objectives and any significant events affecting him. (2.34)
Not achieved. While personal officer entries in wing files were mostly regular, including electronic case notes in the recently introduced P-NOMIS system, most referred only to behaviour on the wings, with occasional mention of a prisoner's allocated activity. There were very few references to family issues or sentence planning and few records indicated that personal officers introduced themselves to prisoners or made direct and regular contact with them to check on progress. This not only meant that progress or otherwise against sentence planning or resettlement objectives went unrecorded, but also had implications for safety.
We repeat the recommendation.

2.37 Prisoners with specific care needs such as older prisoners and those with disabilities should have regularly monitored care plans as part of their wing files. (2.35)
Partially achieved. All prisoners completed a disability questionnaire and support plan during their interview with a nurse on arrival. These were sent to the diversity officer, who interviewed any prisoner disclosing a disability. A needs assessment was completed and a care plan written if required. Thorough initial assessments of care for older prisoners took place at health care clinics. Copies of care plans were put on wing files and when necessary reviewed quarterly by the diversity officer. However, many lacked dates and signatures of those involved, were very basic and gave little information or advice to wing staff on what they needed to do to ensure specific individual needs were met. One man's had been identified as having heart problems on arrival, with a need for ground floor accommodation. He had subsequently had several epileptic episodes on the wing requiring the support of health services staff, but his care plan made no mention of his epilepsy or how it should be managed. Another care plan recorded that a prisoner needed a walking stick on arrival, but the two undated quarterly reviews since then did not indicate that one had been provided or the reason why not. One review stated 'still in pain all the time – no change in condition', with no details of action taken or care needed. All the electronic wing records of prisoners with care plans that we looked at indicated that they had been seen by the diversity officer, but none contained any comment from wing officers demonstrating an awareness of the identified disability and any need.

Further recommendation

2.38 Care plans should be fully completed and give clear, specific and practical advice to residential staff on how to ensure that the additional needs of older men and those with disabilities are met.

Bullying and violence reduction

2.39 A single safer prisons meeting overseeing all safer custody strategies should be held monthly. (3.14)
Achieved. A safer prisons meeting was held monthly chaired by the head of residence. Minutes indicated good attendance and discussion of both anti-bullying/ violence reduction and suicide and self-harm issues.

2.40 A comprehensive survey of prisoners' experiences of bullying and perceptions of safety should be completed. (3.15)
Achieved. The psychology department had undertaken a survey at the end of 2009 and the results were being used, after some delay, to inform the revision of the anti-bullying strategy.

2.41 Staff should receive training in the anti-bullying and violence reduction strategies. (3.16)
Not achieved. The only such training session in the previous 12 months had taken place just before the inspection and had been delivered to staff from education, health care and the kitchen. No staff from the residential units had attended (see also recommendation 2.1).
We repeat the recommendation.

2.42 Interventions for bullies and victims should be developed. (3.17)
Partially achieved. There were some interventions for victims, but those for bullies were underdeveloped. Victims were put forward for the 'turning point' course designed to improve confidence and self-esteem, and the psychology department also carried out one-to-one work. Records of the number of prisoners subject to such interventions were not kept.

Further recommendation

2.43 Interventions for bullies should be developed and formal records maintained by the safer custody department demonstrating what interventions have been provided to bullies and victims.

2.44 Officers should patrol the living blocks frequently and blind spots should be reduced to improve supervision, including through the introduction of closed-circuit television. (3.18)
Not achieved. Staff still mainly remained in wing offices. There were not enough staff to monitor all the landings and the situation was exacerbated when staff had to leave the units to oversee exercise periods. Closed-circuit television had not been installed.
We repeat the recommendation.

2.45 The mix of sex offenders and non-sex offenders on LB5 should be closely monitored. (3.19)
Achieved. Monitoring was regularly carried out at the safer custody meeting, with a focus on specific issues between prisoners as they arose.

Self-harm and suicide

2.46 The suicide prevention policy should be re-written to detail clearly all aspects of the procedures and services available. (3.34)
Achieved. The suicide prevention policy had been reviewed in the previous 12 months. It was comprehensive and guided staff at all levels on their responsibilities and the resources available.

2.47 A new ACCT register should be developed with a clear protocol for maintaining it. (3.35)
Achieved. The assessment, care in custody and teamwork (ACCT) register was maintained in the control room. Staff had to contact the control room to get a reference number to open the book, which helped ensure that all opened ACCTs were reflected in the log.

2.48 Prisoners on open ACCT forms should not arrive at Channings Wood without previous notice and the area safer custody adviser should be informed on any occasion where

this happens. (3.36)
Achieved. The safer custody manager reported, and transfer notices confirmed, that staff had been informed whenever a prisoner on an ACCT was transferred to Channings Wood.

2.49 Case managers should receive training on conducting reviews and ensure that these include an appropriate range of disciplines, that care maps are meaningful and realistic and that they provide appropriate continuity of care. (3.37)
Partially achieved. Apart from three officers temporarily promoted, all senior officers had received case manager training. However, other disciplines experienced in case management, such as psychologists and drugs workers, had not. The care maps we examined were poor quality. One prisoner had been placed on an ACCT after a senior officer had allegedly told him he would never be released and the care map and initial review had both been conducted by the same senior officer. Identified actions were mostly generic and the individual identified as responsible for following up the action concerned was usually the prisoner himself.

Further recommendations

2.50 Case managers should be drawn from a range of disciplines.

2.51 Care maps should be meaningful and realistic and ensure that prisoners receive appropriate care and support from staff.

2.52 ACCT record entries should record evidence of interaction with prisoners, and observations should not be regular and predictable. (3.38)
Not achieved. Some entries indicated quality interactions with prisoners, but too many others simply recorded that the prisoner had said he was 'ok' or were purely observational.
We repeat the recommendation.

2.53 Specific emergency radio codes should be developed to ensure that health care staff know the nature of an emergency and what equipment they will need. (3.39)
Not achieved. No system had been implemented. The prison believed that as only one 'grab bag' with standard equipment was taken by healthcare to all incidents there would be no added value with a coded system. However, a coded system could help first responders know what they were likely to have to deal with and mentally prepare for what they might need to do.
We repeat the recommendation.

2.54 Investigation into near-fatal incidents should be completed to establish what lessons could be learned. (3.40)
Achieved. Both near-fatal incidents in the previous six months had been investigated and had generated recommendations based on lessons learned.

2.55 Prisoners should be introduced to Listeners in reception and on their first night location. (3.41)
Not achieved. Prisoners were not introduced to a Listener until the morning after their arrival.
We repeat the recommendation.

2.56 The chair of the safer prisons meeting should meet regularly with the Listeners and Samaritans to listen to their views on the operation of the Listener scheme and to help promote the contribution that Listeners make to prison life. (3.42)
Achieved. Although the head of residence, who chaired the safer custody meeting, did not meet regularly with Listeners and Samaritans, the safer custody manager met monthly with both. Issues raised at the meeting and non-confidential issues raised in the subsequent

Listeners/Samaritans meeting were recorded and passed on for further discussion at the safer custody meeting.

2.57 Direct-dial Samaritans telephones should be advertised and accessible to prisoners during lock-up. (3.43)
Achieved. Direct-dial Samaritans telephones were now available to prisoners during lock-up and information about them was displayed by prisoner payphones. Prisoners subject to ACCT arrangements were routinely told that these telephones were available.

Diversity

2.58 There should be a full-time diversity officer with a job description and appropriate training. (3.57)
Achieved. The full-time diversity officer had a job description and relevant training.

2.59 Disabled prisoners should be involved in the development of the disability policy and consulted, along with older prisoners, about their individual needs and care. (3.58)
Partially achieved. The disability statement and policy was dated 2008 and disability had been included in the draft diversity policy, but prisoners had not been involved in the development of the policy. Regular meetings and activities organised for older men provided opportunities for them to comment on their care.

Housekeeping point

2.60 Prisoners with disabilities and older prisoners should be consulted about the development of the diversity policy.

2.61 The disability liaison officer should have a job description, receive appropriate training and have sufficient allocated time for the work. (3.59)
Achieved. Disability now came under the remit of the full-time diversity officer.

2.62 Identified carers for older and disabled prisoners should be paid by the prison for this work. (3.60)
Not achieved. There was no formal carer scheme. We were told that other prisoners willingly helped those less able and consequently there was no identification or assessment of their suitability for this role.

Further recommendation

2.63 A formal prisoner carer or peer support scheme should be introduced and carers provided with suitable training and pay.

2.64 Monitoring should be introduced to ensure that prisoners from minority groups are not victimised or excluded from activities. (3.61)
Not achieved. Apart from race equality monitoring, there was no monitoring of outcomes for other minority groups.
We repeat the recommendation.

2.65 The diversity meetings should focus on prisoner issues and include prisoner representation. (3.62)

Achieved. Prisoner diversity issues were now included at the race equality meetings, which were attended by prisoner diversity representatives.

2.66 All staff should receive quality diversity training. (3.63)
Not achieved. In the previous three years, only 45% of staff had received diversity training and only 8% had attended the Prison Service 'Challenge it, Change it' race equality training.
We repeat the recommendation.

2.67 Disabled assessment booklets should be reviewed and updated regularly. (3.64)
Not achieved. Disabled assessment booklets had been replaced by care plans, but these were not regularly reviewed (see section on personal officers).

Additional information

2.68 Over 50s forums led by the Age Concern Older Offenders Project (ACOOP) were well run on both the vulnerable prisoner unit and in the main prison. Meetings were advertised and ran weekly, with guest speakers and activities of interest to older prisoners.

Race equality

2.69 The race equality action team should meet monthly and should include all functional managers and external representatives. (3.75)
Achieved. The race equality action team met monthly. Meetings were attended by all relevant managers and often included external representatives.

2.70 There should be a full-time race equality officer. (3.76)
Achieved. There was a full-time race equality officer.

2.71 The role of the officer wing diversity representatives should be evaluated and formalised. (3.77)
Achieved. Officer wing diversity representatives had a job description and received suitable training.

2.72 Individual wing jobs should be monitored by ethnicity. (3.78)
Achieved. Wing jobs were monitored by ethnicity, but some black and minority ethnic prisoners were unaware of this and complained that the 'better' jobs went to white prisoners.

2.73 Race equality action team minutes should fully record discussion of SMART data to support the decisions made. (3.79)
Achieved. Minutes of meetings indicated suitable discussion of monitoring data.

2.74 There should be regular and effective consultation with black and minority ethnic prisoners. (3.80)
Not achieved. Black and minority ethnic prisoner forums had been set up, but meetings planned so far in 2010 had been cancelled for various reasons and the last meeting had been in December 2009. The perception that white prisoners got the better jobs had been raised at the December meeting, but there had been no subsequent meetings to allay this concern.
We repeat the recommendation.

2.75 Regular events should be held to promote and celebrate racial, ethnic and cultural diversity to prisoners and staff. (3.81)
Achieved. Regular events were held to celebrate racial and cultural diversity.

2.76 Prisoner diversity representatives should be chosen by prisoners. (3.82)
Achieved. Prisoner diversity representatives were elected by prisoner ballot. They met with the diversity manager monthly and all had received formal training for their role.

Additional information

2.77 Racist incident reports were investigated promptly and thoroughly. Completed reports were scrutinised by representatives from an appropriate external agency.

Foreign national prisoners

2.78 There should be a comprehensive foreign national prisoner policy based on a needs analysis and with agreed targets for progress. (3.96)
No longer relevant. The prison no longer held many foreign national prisoners and there were only two during the inspection. Foreign national men were usually moved quickly to HMPs Dartmoor, The Verne or Guys Marsh.

2.79 A senior manager clearly identified to prisoners and staff should be responsible for the development and provision of services to foreign national prisoners. (3.97)
Achieved. The diversity officer was responsible for supporting foreign national prisoners and saw each one individually to identify any specific needs.

2.80 The foreign national liaison officer should have a job description, and receive dedicated time for the work, and appropriate training and management support. (3.98)
Achieved. The diversity officer was full time and had received relevant training.

2.81 The foreign national liaison officer should attend race equality and diversity management meetings and foreign national issues should be a standing item on the agenda. (3.99)
Achieved. The diversity officer attended race equality action meetings and raised any foreign national issues when necessary.

2.82 Accredited translation and interpreting services should be used for foreign national prisoners whenever matters of accuracy and confidentiality are a factor. (3.100)
Achieved. Although rarely needed, prison staff had access to a professional telephone interpreting service and a range of information was available in different languages on the intranet.

2.83 Accurate records of staff and prisoners willing to speak languages other than English should be kept and prisoner interpreters should be rewarded for their work. (3.101)
No longer relevant. Few foreign national prisoners remained at the prison.

2.84 Regular contact should be made with accredited independent immigration advice and support agencies. (3.102)
No longer relevant. There was no longer a need for this support, but the diversity officer had links with UK Border Agency staff based at HMP The Verne if necessary.

2.85 Support groups for foreign national prisoners should be held regularly and areas of concern fed back to senior managers. (3.103)
No longer relevant. There was no longer a need for these groups.

Applications and complaints

2.86 Local information about the applications and complaints system should be available in a range of languages. (3.132)
Achieved. Some information was available in languages other than English, but the prison rarely held many foreign national prisoners (see section on foreign nationals). Most of those who stayed were English speakers.

2.87 The effectiveness of the applications system should be monitored for quality and promptness of reply. (3.133)
Not achieved. The application system was not monitored for quality or promptness of reply. Many prisoners complained that they had to repeat or chase up applications.
We repeat the recommendation.

2.88 There should be more detailed analysis of the nature of complaints logged under confidential access and property. (3.134)
Achieved. There was now a system to identify the subject nature of confidential access complaints and there was good detailed analysis of all complaints.

2.89 Monthly sample quality checks of responses to complaints should be documented. (3.135)
Achieved. Monthly samples of responses to complaints were usually carried out by the deputy governor, who gave appropriate feedback as required.

Legal rights

2.90 The legal services officer should be allocated sufficient and regular hours for this work. (3.142)
Not achieved. The action plan indicated that more legal services officers were available, but only one officer was regularly detailed and he was often deployed to other work. There was no legal services officer on duty for the first three days of the inspection.
We repeat the recommendation.

2.91 Recalled prisoners should be identified promptly and given information about recall procedures and the help available. (3.143)
Achieved. Offender management unit (OMU) case administrators were now responsible for this task and ensured that recalled prisoners had the appropriate information, most of which had been provided in local prisons.

Substance use

2.92 A comprehensive secondary detoxification policy should be introduced in line with national guidance. (3.155)
Not achieved. The prison had adopted the detoxification policy of HMP Dartmoor, published in 2007. It did not include information about secondary detoxification for prisoners who relapsed while in prison. The drug strategy document contained a detoxification policy statement for 2008/09, but there were no review dates or staff signatures stating they had read and understood the policies. The integrated drug treatment system (IDTS) had been introduced and about 40 prisoners were receiving substitute medications. There was an identified area for dispensing controlled drugs and iris recognition was used to support methadone administration. There were no locally developed IDTS policies or protocols specific to

Channings Wood. Secondary detoxification options included symptomatic relief, Lofexidine and Naltrexone, which was insufficient as methadone maintenance was not offered to prisoners who relapsed in prison. Retoxification was offered for prisoners assessed as high risk of overdose on release.

Further recommendation

2.93 All IDTS policies and protocols should be updated to reflect National Treatment Agency requirements and to be specific to Channings Wood. There should be a clear ratification process, with documents including signatures and review dates.

Housekeeping point

2.94 The detoxification policy should include a statement about secondary detoxification for prisoners who relapse in prison and retoxification before release.

2.95 Protocols and procedures supporting effective joint working between the CARAT service and health care should be reinforced to ensure joint care planning is undertaken for prisoners receiving clinical support for substance misuse. (3.156)
Achieved. Joint working protocols had been agreed between CARATs and health care, and between CARATs and the offender management unit. Joint care planning had improved through weekly meetings between the CARAT service and health care. A dedicated compliance-based drug testing (CBDT) coordinator had been appointed in October 2009 and, to enhance integration, there were immediate plans for a nurse to work full time and be based in the CARAT office.

2.96 Drug testing figures should be collated by type and separated by wing to ensure effective management information. (3.157)
Not achieved. Testing rates were held on a spreadsheet and collated by individual prisoner names. They were not analysed by wing to identify problem areas.
We repeat the recommendation.

2.97 Mandatory drug testing should be appropriately staffed to ensure that all testing is carried out appropriately, within identified timescales and without gaps in provision. (3.158)
Not achieved. The MDT rate for 2009/10 was 6%. The year to date figure to June 2010 was 13.6%. There were some wide variations between months and the positive rate had been as high as 17% in one recent month. All prisoners on release on temporary licence were tested on return from leave. A review of the log identified that testing had been too predictable. During the period October 2009 – March 2010, 79% of tests had been carried out in the first two weeks of the month. This had changed over the period of April – June 2010, when 76% of all tests were carried out in the last two weeks of the month. Suspicion testing in the year was so far was 47.1%, suggesting reasonably good security intelligence. MDT staff were not always detailed to work in the suite and were moved to support other areas of the prison.
We repeat the recommendation.

Health services

2.98 The health care manager should meet with other prison managers, including those responsible for safer custody and resettlement, to ensure that health care staff provide any necessary input to the overall management of prisoners. (4.46)

Partially achieved. The health care manager was a member of the senior management team. She and deputy managers represented the department at public protection, safer custody, drug strategy, multi-agency public protection arrangement and security meetings. However, minutes of these meetings indicated that their attendance was limited.

Housekeeping point

2.99 The health care manager or a representative should attend all meetings where their input would help improve prisoner care.

2.100 A day care service should be provided for older prisoners and those who have difficulty coping with life on the wings. (4.47)
Not achieved. There were no day care services for older prisoners or those who found it difficult to cope with life on the wings. Prisoners finding it difficult to cope had their needs reviewed by the disability nurse.
We repeat the recommendation.

2.101 The mental health teams should introduce multidisciplinary meetings that include representation from appropriate departments and personal officers. (4.48)
Achieved. Multidisciplinary meetings were held every two weeks involving nursing staff, a psychiatrist, a psychologist and Mind. Residential staff were involved when specific concerns were identified with prisoners.

2.102 Mental health awareness training for staff should be introduced and updated annually. (4.49)
Not achieved. There was a new provider of mental health training, which had just begun. So far, only 21 of the 256 eligible staff had received training.
We repeat the recommendation.

2.103 A secure gate with a lock-back facility should be fitted to the treatment room on LB5. (4.50)
Not achieved. There was no gate with a lock-back facility on the LB5 treatment room.
We repeat the recommendation.

2.104 Mandatory cardiopulmonary resuscitation training should be completed on time. (4.51)
Not achieved. Records showed that not all clinical staff had received annual resuscitation or defibrillation training. Nursing staff had transferred their employment to Devon Partnership Trust in August 2009 and the organisation was about to review the timescales for mandatory training.
We repeat the recommendation.

2.105 A dedicated health care forum should be established where wing representatives can meet health care managers to provide a service-user perspective. (4.52)
Not achieved. There was no specific health care forum for prisoners, nor was there a standing agenda item or records to identify regular attendance at wing representative meetings. The health care manager attended the over-50s meeting in the vulnerable prisoner unit.
We repeat the recommendation.

2.106 Formal documented triage algorithms should be used to ensure consistency and continuity of care and advice given to prisoners. (4.53)
Partially achieved. Protocols were available for chest pain and asthma and a mental health

risk assessment was used. The health care manager was adapting the minor injuries algorithms.

2.107 All medication policies should be formally reviewed, adopted and signed by the medicines and therapeutics committee. (4.54)
Not achieved. The medicines policy had been ratified for a period of four months in March 2010, but there was no clear ratification process for all medication policies and protocols, including signatures and review dates on documents. The medicines and therapeutics committee had been re-established in 2010 and its priorities were being reviewed.
We repeat the recommendation.

2.108 Pharmacy staff should ensure that medicines issued to prisoners reporting sick are labelled with the patient name, date of supply and directions for use. (4.55)
Not achieved. Prisoners could request paracetamol or ibuprofen as in possession medication when reporting sick and this was recorded on their drug chart. No nurse issue medications were labelled with the prisoner's name, date of supply or directions for use before administration.
We repeat the recommendation.

2.109 Pharmacy staff should regularly audit the records of drugs used in an emergency out of hours and reconcile these records with the clinical records held. (4.56)
No longer relevant. In possession medication was available and there was out-of-hours medical cover for emergencies. A nurse was available until 7.45pm and a pharmacist was available by telephone out of hours if needed.

Additional information

2.110 A lead nurse ran clinics for older prisoners and all men over the age of 55 were offered a thorough initial assessment. Each prisoner was followed up every six months by a health care assistant and relevant information was shared with the OMU. The older prisoner policy reflected the National Service Framework for older people, but had been developed for prisoners over 60. The health needs assessment, written in 2008, did not sufficiently reflect the needs of older prisoners.

2.111 There had previously been a number of complaints from prisoners about long waits for dental appointments. Since a new dental contract had been commissioned in April 2010, emergency patients could be seen immediately and the wait for a routine appointment was about five weeks. A room linked to the dental area was awaiting refurbishment as there were insufficient sterilisation areas.

2.112 Mental health services had been restructured across the South West prisons cluster, resulting in a richer skill mix in the primary mental health team and no community psychiatric nurse. These service changes were new and there had been no time for any impact assessment. A cluster health needs assessment completed in 2008 noted an underreporting of mental health problems and a tendency towards reactive responses to mental health needs. It contained no information about prisoners' drug and alcohol needs.

2.113 Nurses still had no telephone in the reception health care office. The British National Formulary editions in clinical areas were out of date.

2.114 A wide range of training opportunities was available for clinical staff, but there were difficulties accessing safeguarding adults training through the primary care trust and only two staff had completed it.

Further recommendations

2.115 A health needs assessment for older prisoners should be completed to inform the development of services and the older prisoner policy.

2.116 A new sterilisation area should be provided in the dental surgery to ensure that clean and dirty areas are separated.

2.117 The health needs assessment should be updated to identify any gaps in service for prisoners with mental health needs or dual diagnoses.

Housekeeping points

2.118 There should be a telephone in the reception health care room.

2.119 All old editions of the British National Formulary should be discarded and up-to-date editions provided.

2.120 All clinical staff should be updated in their safeguarding adults training.

Learning and skills and work activities

2.121 Learning plan targets should be more specific and better related to individual learning goals. (5.13)
Achieved. Education providers worked collaboratively to provide development sessions for staff. Learning plan targets had improved and plans were more specific and better related to individual learning goals.

2.122 Internal verification of accredited training should be improved so that full qualification certificates can be issued speedily to prisoners. (5.14)
Achieved. The internal verification process had improved. A systematic internal and external verification cycle has been put in place, monitored through quality improvement group meetings. Most qualification certificates were issued in good time and before a prisoner's release. When this was not possible due to external verification delays, prisoners were encouraged to leave a forwarding address so that certificates could be sent.

2.123 More prisoners employed in workshops should participate in accredited training programmes. (5.15)
Achieved. The range and number of accredited training courses offered alongside employment in the workshops had increased significantly. The prison offered a wider range of more appropriate qualifications and these were followed by an increased number of prisoners.

2.124 The library should be made more accessible to men from the vulnerable prisoner unit. (5.16)
Not achieved. Library sessions for vulnerable prisoners had increased from one hour to two, but were still often cancelled. The small library set up in the vulnerable prisoner unit comprised donated and deleted stock that did not adequately meet prisoners' needs.
We repeat the recommendation.

Additional information

2.125 Of the 588 activity places, 182 were in education and training, mainly full time, and 342 were in employment, much of it with training. This compared to 142 and 358 respectively at the last inspection. A further 64 places were in the drug therapeutic community. Around 18% of prisoners were routinely unemployed compared to 20% previously. Education and training courses ran each weekday for a total of 27.5 hours. There were no evening classes apart from recreational PE. Recreational classes were still offered at weekends and had been extended to include horticulture support and education for older prisoners from the vulnerable prisoner unit who managed their own allotments at the prison.

2.126 The learning and skills department continued to run a good range of education and training, including literacy, numeracy, ICT, social and life skills, pottery and creative arts, forklift truck driving training, painting and decorating, customer services, industrial cleaning, family relationships and a peer advisory programme. Improvements to the range included dry lining and stud walling, the construction site safety certificate (CSCS), electrical installation, hard landscaping, and food service and preparation. A new creative media course was offered to all prisoners, as was a new 'managing transition' course for prisoners within three months of release. New courses had been planned with reference to the South West Regional Development plan to take account of local and regional employment needs. Most training courses were offered at level 2.

2.127 Learning pods (classroom areas) had been installed in all workshop areas. These were effectively used by prisoners to work on qualification portfolios and to receive additional literacy and numeracy support if required while they remained in the workshops available for work.

2.128 There were some very effective partnerships to expand work opportunities for prisoners within and outside the prison. Some were at an early stage of development and currently involved few prisoners, but all had been developed successfully to enhance employment opportunities. Work with Sainsbury's had led to the local employment of two current prisoners, while future prisoners on this scheme would be guaranteed a job interview with Sainsbury's. Prisoners obtaining the laundry operative qualification and the new waste management and recycling course were also guaranteed a job interview with a national laundry and a recycling employer. Two prisoners had found work with Barnardo's using release on temporary licence.

2.129 The prison had successfully introduced the manufacture of new products and extended its current range to widen the type of work available to prisoners in the workshops and secure cost effective contracts to offset those lost through government cutbacks. These included the production of picnic benches and poultry arcs and the extension of a contract to produce part-finished kitchen chalk boards.

Physical education and health promotion

2.130 The sports hall roof should be repaired or replaced. (5.23)
Achieved. The sports hall roof had been repaired and the facility was now better used.

2.131 More recreational physical education should be provided during the core day. (5.24)
Achieved. More recreational PE was provided during the core day. Another member of staff has been appointed and 15 additional recreational PE sessions were run during the core day, arranged around the needs of employed prisoners.

Additional information

2.132 Wing-based seven-a-side sports leagues had been introduced on three evenings a week in the summer months, along with an additional evening for vulnerable prisoners with a choice of activities. A well-used activity trail had been developed and good use was made of the fitness suite and outside sports areas.

Time out of cell

2.133 Recording of time out of cell should accurately reflect prisoners' experience rather than the prison's core day. (5.35)
Not achieved. The monthly time out of cell figure varied between 8.6 and 9.6 hours a day. Given that the core day allowed for a maximum of nine hours a day and only approximately 80% of prisoners could be employed in prison activities, this was an unrealistic reflection of prisoners' experiences.
We repeat the recommendation.

2.134 Staff training should be arranged to ensure minimum impact on time out of cell. (5.36)
Not achieved. The majority of the prison was still locked up one day a month while staff training was carried out.
We repeat the recommendation.

2.135 Outside exercise should be effectively supervised, seats provided and prisoners issued with weatherproof clothing when necessary. (5.37)
Not achieved. Outside exercise was not effectively supervised. Up to four staff were outside during exercise, but most stayed in one place rather than patrolling the large area.
We repeat the recommendation.

2.136 Staff should record the number of prisoners who do not participate in association and establish the reasons why. (5.38)
Not achieved. No records were maintained by staff on any of the units.
We repeat the recommendation.

2.137 A wider range of association facilities should be provided to meet the needs of less fit and able prisoners. (5.39)
Achieved. A suitable range of board games and jigsaw puzzles was now available.

Security and rules

2.138 A clear strategy should be devised to minimise the problem of rooftop protests. (6.7)
Achieved. Danet wire had been erected where considered necessary, specifically around the housing blocks. The number of rooftop incidents had decreased and rooftop incidents were now confined to the education and chapel roofs where they were more effectively managed as a limited regime could be run rather than a complete lock-down. There was an incident during the inspection and there was a commendable emphasis on maintaining as much of the regime as possible without compromising the management and safe de-escalation of the incident.

2.139 Prisoners should be given a written explanation of re-categorisation board findings and what they need to do to help them progress to lower security conditions. (6.8)
Achieved. Although only basic information was provided, prisoners were given slips explaining the decision of re-categorisation boards and the reasons for them.

Discipline

2.140 The prison should analyse the use of adjudications, segregation and use of force to look for patterns and trends that might help reduce the number of incidents and prisoners involved. (6.20)
Partially achieved. Analysis of adjudication data was a standing agenda item at adjudications meetings. However, the minutes contained little detail of associated discussion and there were no subsequent action points when trends were identified. Segregation data were monitored at the bi-annual SMARG meeting, but minutes provided no information on trends identified or subsequent action points. Use of force was monitored at the monthly safer custody meeting. Although analysis was limited, use of force was low and there was little need for more sophisticated analysis.

Housekeeping point

2.141 Minutes of the adjudications and SMARG meetings should fully reflect the discussion of analysis of adjudication and segregation data and any subsequent action points when trends are identified.

2.142 Adjudicators should establish that health care staff have checked the names of all prisoners placed on report and call for additional information where there are indications that a prisoner might not be fit. (6.21)
Partially achieved. Health care staff did not routinely check the details of prisoners placed on report. Adjudicating managers said they adjourned proceedings if they had any concerns about a prisoner. This was confirmed by segregation unit staff, although we were not given specific examples.

2.143 Regular adjudication standardisation meetings should monitor the quality of adjudications to ensure that full enquiries are made into charges and that punishments given are consistent with up-to-date tariff guidance. (6.22)
Achieved. The standing agenda at a quarterly adjudications meeting included feedback from the governor, who carried out a 10% random sampling of adjudication records.

2.144 All use of force documentation should be certified by a manager not involved in the incident. Senior managers should routinely monitor completed use of force documents to satisfy themselves that force used was necessary and proportionate and that all documentation, including health care contributions, is properly completed. (6.23)
Not achieved. Use of force documentation was almost always signed off by a manager involved in the incident, usually the orderly officer. We were told that a developing Prison Service manager reviewed all documents, but there was no formal evidence of this and no senior manager carried out such a check.
We repeat the recommendation.

2.145 All planned use of force should be recorded on video camera. (6.24)
Achieved. All planned use of force was videoed using a camera held in the segregation unit.

2.146 The regime in the segregation unit should be improved with the introduction of some activities. (6.25)
Achieved. In-cell education was now available to prisoners in the segregation unit and there was a larger stock of regularly changed library books. Puzzle books and jigsaws were also provided.

2.147 The formalised practice of moving prisoners from segregation unit to segregation unit within the area should cease. (6.26)
Achieved. Records indicated that no prisoners had transferred to the segregation unit from another segregation unit in the previous six months and all prisoners transferring out of Channings Wood in the previous three months had gone to mainstream location.

2.148 Prisoners entering the segregation unit should not be strip-searched routinely but on the basis of an individual risk assessment. (6.27)
Not achieved. All prisoners locating to the segregation unit were routinely strip searched.
We repeat the recommendation.

2.149 Cardboard furniture should not be used in segregation unit cells unless there is an established risk. (6.28)
Not achieved. Some prisoners in the segregation unit had been given cardboard furniture. Staff said this was on the authority of an operational manager, but there was no formal risk assessment process to support these decisions.
We repeat the recommendation.

2.150 Use of the special cell should always be documented and authorised. (6.29)
Achieved. Special accommodation had been used only once in the previous 12 months. Documentation for this and previous occasions was well completed and recorded and carried the appropriate level of authorisation.

2.151 Daily history sheet entries in the segregation unit should provide evidence of positive interaction with prisoners and report on their well-being. (6.30)
Achieved. Unit staff were caring and supportive towards prisoners and this was reflected in generally good quality daily entries in history sheets, which indicated positive interactions.

2.152 Effective care plans with specific targets should be developed for prisoners held in the segregation unit for more than 30 days. (6.31)
Not achieved. Care plans had been introduced in line with the recently revised Prison Service Order 1700, but those we examined were poor quality, with targets that did not identify or address why individual prisoners remained in the segregation unit.
We repeat the recommendation.

2.153 The external fabric of the segregation unit should be enhanced including repairs to the windows and improvements to the exercise yard. (6.32)
Not achieved. The external fabric of the segregation unit, particularly the exercise yard, was in very poor condition. The windows had not been repaired and a fire in one cell had left the external grille in a particularly bad state. The exercise yard was cleaned only once a week and there were piles of accumulated rubbish in the corners. There was graffiti on the exercise yard walls and a bottle of urine was hanging from the danet wire around the wall.
We repeat the recommendation.

Incentives and earned privileges

2.154 The prison should review the privileges of each level of the incentives and earned privileges scheme in consultation with prisoners to encourage responsible behaviour and compliance with sentence plan targets. (6.39)
Partially achieved. Prisoners had been consulted about the incentives and earned privileges scheme and this had continued at prisoner representative meetings, where the lack of incentives for enhanced prisoners was regularly discussed.

Further recommendation

2.155 Additional facilities and privileges should be available for enhanced prisoners to provide real incentives for responsible behaviour and engagement with sentence plan targets.

2.156 Incentives and earned privileges should be clearly linked to sentence plan targets and not just behaviour on wings. (6.40)
Achieved. Compliance with sentence plan targets was appropriately considered when deciding regime level.

Catering

2.157 Appropriate arrangements for preparing and serving halal food should be made and enforced in the kitchen and on wing serveries. (7.10)
Achieved. Halal implements were colour coded and appropriate procedures followed, but halal implements on some serveries were stored with other cooking utensils.

2.158 Appropriate clothing should be worn by servery workers. (7.11)
Achieved. The servery workers were appropriately dressed.

2.159 Lunch should not be served before noon and tea not before 5pm. (7.12)
Partially achieved. Meal times were appropriate on weekdays, but early at weekends. This was unlikely to change unless the national core day arrangements were rescinded.

2.160 A served breakfast should continue to be provided. (7.13)
Achieved. Breakfast packs had not been introduced.

2.161 Food comments books should be available on all wings. (7.14)
Achieved. Food comments books were available and comments were regularly reviewed and responded to by the catering manager. Prisoners had mixed views about the quality of the food. Many agreed that the quality was mostly reasonable, but a number said the portions were inadequate.

Prison shop

2.162 Prisoners should not be charged an administration fee for catalogue orders. (7.20)
Achieved. Prisoners paid a standard £1 delivery charge for catalogue orders as part of the national contract, but the prison no longer charged a separate administration fee.

Strategic management of resettlement

2.163 The action plan linked to the resettlement strategy should be specific, measurable and time-bounded. (8.7)
Achieved. The action plan was specific and time-bounded. However, although the reducing reoffending strategy included the reducing reoffending pathways with identified leads, the action plan did not include planned targets for the development of all pathway areas. Some resettlement needs analysis had been completed, but this mainly related to factual information and offending behaviour interventions rather than areas such as contact with children and families, which was a particular issue as many men were a long way from home.

Further recommendation

2.164 The resettlement strategy action plan should include planned targets to develop all pathways.

Additional information

2.165 The reducing reoffending team met every three months chaired by the head of reducing reoffending. Minutes showed that some managers did not contribute to decision making and there had been no representatives from health care, drug strategy or head of operations at the three meetings between July 2009 and April 2010.

Housekeeping point

2.166 All functional managers should attend reducing reoffending meetings or send a representative.

Offender management and planning

2.167 A strategic plan for the roll-out of the offender management model should be drawn up to set out how all elements will be resourced, delivered and monitored. (8.26)
No longer relevant. The offender management unit (OMU) had been established for some time.

2.168 Offender supervisor records should demonstrate good knowledge of the prisoner and detailed case management, and prisoners should know who their offender supervisor is. (8.27)
Achieved. Offender supervisor records showed good knowledge of prisoners and the work undertaken with them. However, not all offender supervisors maintained electronic case notes that were freely accessible by other staff, including wing officers.

Housekeeping point

2.169 Notes made by offender supervisors should be accessible to all prison staff.

2.170 The offender management unit should become the driving force behind all prisoner progression-related decisions for prisoners within its scope, including release on temporary licence, activity allocations, recategorisation, interventions and transfers. (8.28)
Partially achieved. The OMU was well established, but was not yet managing all prisoner progression decisions. It was not yet involved in managing re-categorisation, although this was planned.

Further recommendation

2.171 The offender management unit should manage re-categorisation for prisoners.

2.172 A named person should be responsible for ensuring that the required actions identified in the resettlement needs assessment are completed. (8.29)
No longer relevant. The resettlement needs assessment no longer existed.

2.173 Video conferencing should be used to maintain contact with offender managers in the community and a record of its use should be kept. (8.30)
Achieved. Video conferencing had been used 26 times in 2010, 11 of these for sentence plan reviews and 15 for parole applications. Telephone conferencing was used more often because OMU staff found this easier to organise.

2.174 Life-sentenced prisoners should not be transferred to Channings Wood to undertake programmes unless they are able to do so within 12 months of arrival. (8.31)
Not achieved. Life-sentenced prisoners still came to Channings Wood to complete the cognitive self-change programme, for which there was a 2.5 year wait.
We repeat the recommendation.

2.175 Life-sentenced prisoner moves to open prisons should not be unduly delayed because of the failure to provide suitable facilities. (8.32)
Achieved. No recent moves to open prisons had been delayed by lack of suitable facilities.

2.176 The lifer liaison officer should be given dedicated facility time and a job specification. (8.33)
Achieved. A dedicated lifer senior officer received dedicated time for the work and had a job description.

Additional information

2.177 The OMU was managed by the head of interventions and included offender supervisors, public protection and lifer staff. The 13 offender supervisors were a mix of probation, discipline and probation support officers. There were eight case administrators. All prisoners were allocated an offender supervisor irrespective of length of sentence. The name of the allocated offender supervisor was displayed in prisoners' cells alongside that of their personal officer. However, it was unclear how well the role of offender supervisor was communicated to, and understood by, prisoners. Many complained that they had not met their offender supervisor or did not meet them regularly.

Housekeeping point

2.178 The role of offender supervisor should be clearly explained to prisoners.

Resettlement pathways

2.179 The number of prisoners discharged with no fixed abode should be reduced significantly. (8.37)
Achieved. Approximately 10% of prisoners were released with no fixed address compared to 20% in 2007.

Additional information

2.180 Accommodation services were provided by a worker from St Giles Trust based full time at the prison. All prisoners were seen by trained prisoner housing representatives shortly after arrival and referrals were made when necessary. A JobCentre Plus worker helped with benefits and finance, and debt advice was also available. Prisoners could open bank accounts. Prisoners were very positive about the information and advice service and some good pre-release courses were run.

2.181 All prisoners should be given effective guidance and help with finding education, training and employment after release. (8.43)
Achieved. An employment worker had been appointed to link with the resettlement department and liaise more effectively with advice and guidance staff. Programmes had been introduced offering effective guidance, mentoring and support to find and sustain education, training and employment after release. Training and employment in the workshops was effectively linked to local and regional employment opportunities, but information was not collected and analysed to ensure that the interventions were appropriate to individual prisoners.

Further recommendation

2.182 Data on the impact of interventions to support education, training and employment post release should be collected and analysed to ensure they are effectively targeted.

2.183 Prisoners should be told how to register with a GP before release. (8.50)
Achieved. A comprehensive discharge screening clinic was available to all prisoners. A discharge check list was used and prisoners were told how to register with a GP.

2.184 The drug strategy document should include annual developmental targets and objectives. (8.59)
Partially achieved. The drug and alcohol strategy was dated June 2010. The action plan had limited objectives and target dates.

Further recommendation

2.185 The drug and alcohol action plan should have specific action points, with clear timescales for implementation.

2.186 A comprehensive substance use needs analysis of the prison's population should be carried out to inform service development and ensure appropriate levels of CARAT provision. (8.60)
Not achieved. Information was collated to report to the National Treatment Agency, South West Strategic Health Authority and the area office. There was no overall integrated substance use needs assessment or analysis to inform service development and enhance integrated working.
We repeat the recommendation.

2.187 The CARAT team should develop an effective means of prioritising cases to ensure the most effective use of resources. (8.61)
Achieved. Records were received from the transferring prison and a 'T' card system was used

to prioritise cases. Cards were marked when prisoners self-referred from within the prison so they could be assessed promptly.

2.188 One-to-one structured interventions should be available to all prisoners whose treatment needs require it. (8.62)
Achieved. Time-limited one-to-one interventions were offered as required following an initial assessment and one-to-one interventions could be provided in addition to group work. Prisoners spoke positively of the counselling, assessment, referral, advice and throughcare (CARAT) service and the help they received.

2.189 The prison drug strategy group, in developing and implementing its alcohol strategy, should ensure that treatment options are included. (8.63)
Partially achieved. The drug and alcohol strategy contained a brief summary of the options for treatment of alcohol users. These included group work, referral to 'Beyond the Gate' (a Christian organisation offering programmes for alcohol users) and Alcoholics Anonymous. The strategy was not based on a needs assessment and was limited and there were no alcohol use-related objectives in the action plan.

Further recommendation

2.190 There should be a wider range of interventions for prisoners with alcohol problems.

2.191 Voluntary drug testing should not be linked to incentives and earned privileges. (8.64)
Achieved. The compliance-based drug testing (CBDT) coordinator ensured that voluntary drug testing remained separate from incentives and earned privileges. There were 408 compacts, 65% of which related to compact-based tests and 35% to voluntary drug tests.

2.192 The recommended number of tests should be carried out each month to reflect the number of voluntary compacts in place. (8.65)
Achieved. In June 2010, there were 483 tests carried out and 408 compacts. Of these, 10 positive tests were recorded (2.1%).

2.193 Prisoners for the drug therapeutic community should be recruited primarily from the South of England. (8.66)
Partially achieved. There had recently been two open days for staff from other establishments to raise awareness of what the therapeutic community (TC) offered. There was a focus on recruiting participants from prisons in South West, South coast and London prisons and referrals by CARAT teams had increased. TC staff visited local prisons to talk to CARAT teams and OMU staff. Brochures and posters had been produced to circulate inside and outside the prison.

2.194 Once they have completed the therapeutic community programme, prisoners should be able to return to the establishment they came from or an alternative closer to home. (8.67)
Achieved. Governors from transferring prisons signed an agreement that any prisoner deselected from the TC would be returned to his original establishment. No prisoners on the TC were waiting for transfer to another prison, but there were difficulties moving deselected prisoners to the main wings in Channings Wood.

Further recommendation

2.195 Deselected prisoners should be moved quickly from the therapeutic community to the main wings.

Additional information

2.196 Transport difficulties led to delays in receiving prisoners assessed as suitable into the TC. Of the 60 prisoners on the TC, 19 were either deselected participants or new arrivals to Channings Wood awaiting a space on the first night and induction wing (see section on first days in custody).

Further recommendation

2.197 Prisoners should be moved to the therapeutic community from other establishments with the minimum of delay.

2.198 There should be at least one telephone for every 20 prisoners on a wing and all telephones should be in booths. (3.116)
Not achieved. There were not enough telephones on wings and calls could not be made in private.
We repeat the recommendation.

2.199 Visits should start at the advertised time. (3.117)
Not achieved. Visits still started later than the advertised time.
We repeat the recommendation.

2.200 Closed visits should be authorised only when there is a risk justified by security intelligence and not on a single drug dog indication. (3.118)
Not achieved. An indication by the drug dog resulted in the offer of a closed visit or of leaving.
We repeat the recommendation.

2.201 The closed visit facility should be out of sight of other visitors. (3.119)
Not achieved. Those on closed visits could clearly be seen by others in the visits room.
We repeat the recommendation.

2.202 Facilities for visitors to the vulnerable prisoner unit should match those available to visitors in the main prison. (3.120)
Achieved. There was no longer any distinction between visitors for vulnerable and main prisoners and all visitors used the visitors' centre and visits room. Visitors said they were well treated.

2.203 Full details of how to maintain contact with family and friends should be included in induction presentations. (3.121)
Achieved. Induction officers and a family support worker gave verbal information to prisoners during induction.

2.204 Families should be invited to participate in key aspects of prisoners' sentences where appropriate. (8.75)

Achieved. Families were invited to sentence planning reviews and attended post-programme reviews.

2.205 Prisoners should be able to take advantage of accumulated visits to facilitate contact with their children and families. (8.76)
Achieved. No prisoners were delayed for accumulated visits because of cancelled transport during the inspection.

2.206 Children's days should be run for all prisoners. (8.77)
Partially achieved. Children's days had been introduced for all prisoners, but were more frequent for those on the main wings. To date in 2010, three children's days had been run for main location prisoners, while the last children's day for vulnerable prisoners had been in December 2009.

Further recommendation

2.207 Regular children's days should be run for all prisoners.

2.208 Provision should be made for prisoners to receive incoming calls from children or to deal with arrangements for them. (8.78)
Not achieved. There was no such provision.
We repeat the recommendation.

Additional information

2.209 Positive initiatives to help prisoners keep in touch with their families included the provision of emails from family and friends, relationship support through Relate, the Story Book Dads scheme and a parenting skills course in education. A family support worker acted as a link between prisoners and their families. However, the importance of maintaining family ties to help reduce reoffending was generally seen as the work of specialists and was not embedded in personal officer duties. Wing files contained virtually no comment about family contact.

2.210 Delays in assessment for programmes and completion of reports should be significantly reduced. (8.85)
Achieved. There were no delays in programme assessments and completions of structured assessments of risk and need (SARN reports). The programmes available were run to a high standard.

Section 3: Summary of recommendations

The following is a list of both repeated and further recommendations included in this report. The reference numbers in brackets refer to the paragraph location in the main report.

Main recommendations

3.1 A full-time safer custody manager should be appointed to ensure that the anti-bullying strategy is robustly managed, and that staff are aware of and understand their responsibilities to ensure that all incidents of suspected bullying are logged and investigated. (2.1)

3.2 A strategy with clear objectives should be agreed to reduce the supply of drugs in the prison and the consequent violence. (2.2)

3.3 Specific training for personal officers should be introduced so that they are fully aware of what is required of them and the standards expected. (2.4)

3.4 The diversity policy should include all diversity strands, be based on a needs analysis of the population and include an action plan to describe how the needs of all minority groups will be met. (2.6)

3.5 All prisoners should have a minimum of 10 hours a day out of cell including at least one hour in the open air. (2.7)

3.6 Sufficient activity places should be provided to keep all men at Channings Wood purposefully occupied. (2.8)

3.7 A detailed resettlement needs analysis should be completed across all resettlement pathways, taking into account diversity issues, to inform the development of the resettlement strategy and the provision of services. (2.9)

3.8 Channings Wood should not routinely be used to imprison men who live over 100 miles away. (2.11)

Recommendations

To NOMS

Courts, escorts and transfers

3.9 Agreed transfers should be arranged without undue delay. (2.13)

3.10 Prisoners should be given 24-hours notice of planned transfers. (2.15)

First days in custody

3.11 The therapeutic community should not be used as an overflow wing for new arrivals. (2.26)

Resettlement pathways

3.12 Prisoners should be moved to the therapeutic community from other establishments with the minimum of delay. (2.197)

Recommendations

To the governor

First days in custody

3.13 All reception holding rooms should be able to be observed by staff. (2.17)

3.14 New arrivals should be able to shower on the day of arrival. (2.19)

3.15 The induction programme should start the day after arrival and should fully occupy prisoners. (2.23)

3.16 Prisoners should be held in reception for as short a time as possible. (2.25)

Residential units

3.17 Cells designed for one should not be used to accommodate two prisoners. (2.27)

3.18 Shower areas should be refurbished and individual shower cubicles should be provided. (2.30)

3.19 All prisoners should be able to wear their own clothes. (2.31)

3.20 The condition and cleanliness of LB3 should be to the same standard as that of the other units. (2.33)

Staff-prisoner relationships

3.21 Staff should treat prisoners with respect in the way they speak to them, using first name or title according to each prisoner's personal preference. (2.34)

3.22 Officers should patrol the wings regularly during association to allow informal interaction with prisoners, provide a reassuring presence and improve dynamic security. (2.35)

Personal officers

3.23 Personal officers should get to know prisoners' personal circumstances and record contact in wing files to build up an accurate chronological account of a man's time at Channings Wood, his achievement against sentence plan and resettlement objectives and any significant events affecting him. (2.36)

3.24 Care plans should be fully completed and give clear, specific and practical advice to residential staff on how to ensure that the additional needs of older men and those with disabilities are met. (2.38)

Bullying and violence reduction

3.25 Staff should receive training in the anti-bullying and violence reduction strategies. (2.41)

3.26 Interventions for bullies should be developed and formal records maintained by the safer custody department demonstrating what interventions have been provided to bullies and victims. (2.43)

3.27 Officers should patrol the living blocks frequently and blind spots should be reduced to improve supervision, including through the introduction of closed-circuit television. (2.44)

Self-harm and suicide

3.28 Case managers should be drawn from a range of disciplines. (2.50)

3.29 Care maps should be meaningful and realistic and ensure that prisoners receive appropriate care and support from staff. (2.51)

3.30 ACCT record entries should record evidence of interaction with prisoners, and observations should not be regular and predictable. (2.52)

3.31 Specific emergency radio codes should be developed to ensure that health care staff know the nature of an emergency and what equipment they will need. (2.53)

3.32 Prisoners should be introduced to Listeners in reception and on their first night location. (2.55)

Diversity

3.33 A formal prisoner carer or peer support scheme should be introduced and carers provided with suitable training and pay. (2.63)

3.34 Monitoring should be introduced to ensure that prisoners from minority groups are not victimised or excluded from activities. (2.64)

3.35 All staff should receive quality diversity training. (2.66)

Race equality

3.36 There should be regular and effective consultation with black and minority ethnic prisoners. (2.74)

Applications and complaints

3.37 The effectiveness of the applications system should be monitored for quality and promptness of reply. (2.87)

Legal rights

3.38 The legal services officer should be allocated sufficient and regular hours for this work. (2.90)

Substance use

3.39 All IDTS policies and protocols should be updated to reflect National Treatment Agency requirements and to be specific to Channings Wood. There should be a clear ratification process, with documents including signatures and review dates. (2.93)

3.40 Drug testing figures should be collated by type and separated by wing to ensure effective management information. (2.96)

3.41 Mandatory drug testing should be appropriately staffed to ensure that all testing is carried out appropriately, within identified timescales and without gaps in provision. (2.97)

Health services

3.42 A day care service should be provided for older prisoners and those who have difficulty coping with life on the wings. (2.100)

3.43 Mental health awareness training for staff should be introduced and updated annually. (2.102)

3.44 A secure gate with a lock-back facility should be fitted to the treatment room on LB5. (2.103)

3.45 Mandatory cardiopulmonary resuscitation training should be completed on time. (2.104)

3.46 A dedicated health care forum should be established where wing representatives can meet health care managers to provide a service-user perspective. (2.105)

3.47 All medication policies should be formally reviewed, adopted and signed by the medicines and therapeutics committee. (2.107)

3.48 Pharmacy staff should ensure that medicines issued to prisoners reporting sick are labelled with the patient name, date of supply and directions for use. (2.108)

3.49 A health needs assessment for older prisoners should be completed to inform the development of services and the older prisoner policy. (2.115)

3.50 A new sterilisation area should be provided in the dental surgery to ensure that clean and dirty areas are separated. (2.116)

3.51 The health needs assessment should be updated to identify any gaps in service for prisoners with mental health needs or dual diagnoses. (2.117)

Learning and skills and work activities

3.52 The library should be made more accessible to men from the vulnerable prisoner unit. (2.124)

Time out of cell

3.53 Recording of time out of cell should accurately reflect prisoners' experience rather than the prison's core day. (2.133)

3.54 Staff training should be arranged to ensure minimum impact on time out of cell. (2.134)

3.55 Outside exercise should be effectively supervised, seats provided and prisoners issued with weatherproof clothing when necessary. (2.135)

3.56 Staff should record the number of prisoners who do not participate in association and establish the reasons why. (2.136)

Discipline

3.57 All use of force documentation should be certified by a manager not involved in the incident. Senior managers should routinely monitor completed use of force documents to satisfy themselves that force used was necessary and proportionate and that all documentation, including health care contributions, is properly completed. (2.144)

3.58 Prisoners entering the segregation unit should not be strip-searched routinely but on the basis of an individual risk assessment. (2.148)

3.59 Cardboard furniture should not be used in segregation unit cells unless there is an established risk. (2.149)

3.60 Effective care plans with specific targets should be developed for prisoners held in the segregation unit for more than 30 days. (2.152)

3.61 The external fabric of the segregation unit should be enhanced including repairs to the windows and improvements to the exercise yard. (2.153)

Incentives and earned privileges

3.62 Additional facilities and privileges should be available for enhanced prisoners to provide real incentives for responsible behaviour and engagement with sentence plan targets. (2.155)

Strategic management of resettlement

3.63 The resettlement strategy action plan should include planned targets to develop all pathways. (2.164)

Offender management and planning

3.64 The offender management unit should manage re-categorisation for prisoners. (2.171)

3.65 Life-sentenced prisoners should not be transferred to Channings Wood to undertake programmes unless they are able to do so within 12 months of arrival. (2.174)

Resettlement pathways

3.66 Data on the impact of interventions to support education, training and employment post release should be collected and analysed to ensure they are effectively targeted. (2.182)

3.67 The drug and alcohol action plan should have specific action points, with clear timescales for implementation. (2.185)

3.68 A comprehensive substance use needs analysis of the prison's population should be carried out to inform service development and ensure appropriate levels of CARAT provision. (2.186)

3.69 There should be a wider range of interventions for prisoners with alcohol problems. (2.190)

3.70 Deselected prisoners should be moved quickly from the therapeutic community to the main wings. (2.195)

3.71 There should be at least one telephone for every 20 prisoners on a wing and all telephones should be in booths. (2.198)

3.72 Visits should start at the advertised time. (2.199)

3.73 Closed visits should be authorised only when there is a risk justified by security intelligence and not on a single drug dog indication. (2.200)

3.74 The closed visit facility should be out of sight of other visitors. (2.201)

3.75 Regular children's days should be run for all prisoners. (2.207)

3.76 Provision should be made for prisoners to receive incoming calls from children or to deal with arrangements for them. (2.208)

Housekeeping points

First days in custody

3.77 Evaluation of induction questionnaires should be reintroduced for prisoners on the main wings. (2.22)

Diversity

3.78 Prisoners with disabilities and older prisoners should be consulted about the development of the diversity policy. (2.60)

Substance use

3.79 The detoxification policy should include a statement about secondary detoxification for prisoners who relapse in prison and retoxification before release. (2.94)

Health services

3.80 The health care manager or a representative should attend all meetings where their input would help improve prisoner care. (2.99)

3.81 There should be a telephone in the reception health care room. (2.118)

3.82 All old editions of the British National Formulary should be discarded and up-to-date editions provided. (2.119)

3.83 All clinical staff should be updated in their safeguarding adults training. (2.120)

Discipline

3.84 Minutes of the adjudications and SMARG meetings should fully reflect the discussion of analysis of adjudication and segregation data and any subsequent action points when trends are identified. (2.141)

Strategic management of resettlement

3.85 All functional managers should attend reducing reoffending meetings or send a representative. (2.166)

Offender management and planning

3.86 Notes made by offender supervisors should be accessible to all prison staff. (2.169)

3.87 The role of offender supervisor should be clearly explained to prisoners. (2.178)

Appendix I: Inspection team

Michael Loughlin	Team leader
Joss Crosbie	Inspector
Martin Owens	Inspector
Helen Carter	Health care inspector
Linda Truscott	Ofsted inspector

Appendix II: Prison population profile[1]

Population breakdown by:

Status		%
Sentenced	664	91.08
Recall	65	8.92
Convicted unsentenced	0	0
Remand	0	0
Civil prisoners	0	0
Detainees	0	0
Total	729	100

Sentence		%
Unsentenced	0	0
Less than 6 months	16	2.2
6 months to less than 12 months	17	2.33
12 months to less than 2 years	85	11.66
2 years to less than 4 years	194	26.61
4 years to less than 10 years	264	36.21
10 years and over (not life)	19	2.61
ISPP	88	12.07
Life	46	6.31
Total	729	100

Age	Number of prisoners	%
Minimum age = 21		
Under 21 years	0	0
21 years to 29 years	253	34.71
30 years to 39 years	225	30.86
40 years to 49 years	145	19.89
50 years to 59 years	61	8.37
60 years to 69 years	31	4.25
70 plus years	14	1.92
Maximum age = 83		
Total	729	100

Nationality		%
British	723	99.18
Foreign nationals	6	0.82
Total	729	100

Security category		%
Uncategorised unsentenced	0	0
Uncategorised sentenced	0	0
Cat A	0	0
Cat B	0	0

[1] Please note: the following figures were supplied by the establishment and any errors are the establishment's own.

Cat C	722	99.04
Cat D	7	0.96
Other	0	0
Total	729	100

Ethnicity		%
White		
British	649	89.03
Irish	2	0.27
Other white	12	1.65
Mixed		
White and black Caribbean	7	0.96
White and black African	2	0.27
White and Asian	1	0.14
Other mixed	5	0.69
Asian or Asian British		
Indian	4	0.55
Pakistani	2	0.27
Bangladeshi	1	0.14
Other Asian	2	0.27
Black or black British		
Caribbean	21	2.88
African	6	0.82
Other black	9	1.23
Chinese or other ethnic group		
Chinese	0	0
Other ethnic group	2	0.27
Not stated	4	0.56
Total	729	100

Religion		%
Baptist	1	0.14
Church of England	212	29.08
Roman Catholic	96	13.17
Other Christian denominations	77	10.57
Muslim	30	4.12
Sikh	0	0
Hindu	2	0.27
Buddhist	25	3.43
Jewish	2	0.27
Other	50	6.85
No religion	234	32.10
Total	729	100

Sentenced prisoners only

Length of stay		
	Number	%
Less than 1 month	91	12.48
1 month to 3 months	143	19.62
3 months to 6 months	196	26.89
6 months to 1 year	171	23.46
1 year to 2 years	97	13.31
2 years to 4 years	17	2.33
4 years or more	14	1.91
Total	729	100

Unsentenced prisoners only

Length of stay		
	Number	%
Less than 1 month	0	0
1 month to 3 months	0	0
3 months to 6 months	0	0
6 months to 1 year	0	0
1 year to 2 years	0	0
2 years to 4 years	0	0
4 years or more	0	0
Total	0	0

Main offence		%
Violence against the person	167	22.91
Sexual offences	53	7.27
Burglary	117	16.05
Robbery	91	12.48
Theft and handling	14	1.92
Fraud and forgery	2	0.27
Drugs offences	86	11.80
Other offences	61	8.37
Civil offences	0	0
Offence not recorded/holding warrant	138	18.92
Total	729	100